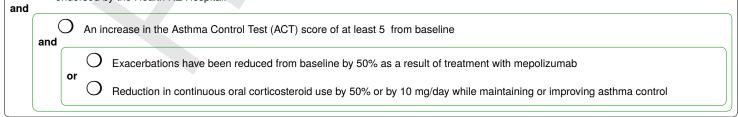
HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

RESC	RIBER	PATIENT:	PATIENT:	
ame:				
ard:		NHI:		
/lepolizumab				
e-ass	sessme	- Severe eosinophilic asthma nent required after 12 months es (tick boxes where appropriate)		
C nd	O Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline endorsed by the Health NZ Hospital.			
	O and	Patient must be aged 12 years or older		
	and	Patient must have a diagnosis of severe eosinophilic asthma documented by a respiratory physician or clinical immunologist		
a	O Conditions that mimic asthma eg. vocal cord dysfunction, central airway obstruction, bronchiolitis etc. have been exclude and			
a	O Patient has a blood eosinophil count of greater than 0.5 × 10 ^{\circ} 9 cells/L in the last 12 months and			
	0	Patient must be adherent to optimised asthma therapy including inhaled corticosteroids (equivalent to at least 1000 mcg per day of fluticasone propionate) plus long acting beta-2 agonist, or budesonide/formoterol as part of the single maintenance and reliev therapy regimen, unless contraindicated or not tolerated		
a	and o	 Patient has had at least 4 exacerbations needing systemic corticosteroids in the previous 12 months, where an exacerbation defined as either documented use of oral corticosteroids for at least 3 days or parenteral corticosteroids Patient has received continuous oral corticosteroids of at least the equivalent of 10 mg per day over the previous 3 months 		
a	and	Treatment is not to be used in combination with subsidised benralizumab	5	
	and O	 Patient has an Asthma Control Test (ACT) score of 10 or less. Baseline measurements of the patient's asthma control using the and oral corticosteroid dose must be made at the time of application, and again at around 52 weeks after the first dose to asses response to treatment 		
		O Patient has not previously received an anti-IL5 biological therapy for their severe eosinophilic asthma or		
		 Patient was refractory or intolerant to previous anti-IL5 biological therapy Patient was not eligible to continue treatment with previous anti-IL5 biological therapy and discontinued within 		
		12 months of commencing treatment TION – Severe eosinophilic asthma		

Prerequisites (tick boxes where appropriate)

O Prescribed by, or recommended by a respiratory physician or clinical immunologist, or in accordance with a protocol or guideline that has been endorsed by the Health NZ Hospital.



HOSPITAL MEDICINES LIST RESTRICTIONS CHECKLIST

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PRESCRIBER	PATIENT:
Name:	Name:
Ward:	NHI:
Mepolizumab - continued	
INITIATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months	
Prerequisites (tick boxes where appropriate)	
O The patient has eosinophilic granulomatosis with polyangiitis	
	n at least one of the following for at least three months (unless nomide, methotrexate, mycophenolate, or rituximab
O The patient has trialled prednisone for a minimum of thr 7.5 mg per day	ee months and is unable to maintain disease control at doses below
O Corticosteroids are contraindicated	
CONTINUATION – eosinophilic granulomatosis with polyangiitis Re-assessment required after 12 months Prerequisites (tick box where appropriate) O Patient has no evidence of clinical disease progression	

I confirm that the above details are correct: